Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator Tom Torlakson
Senator George Runner

February 17, 2005

9:00 AM to 12:30 PM

Room 4203

Informational Hearing:
Governor's Proposed Medi-Cal Redesign

Hospital Financing, Managed Care, and Premiums

(PANEL DISCUSSIONS & PUBLIC COMMENT)

I. Panel to Discuss the Proposed Restructuring of Hospital Financing

Governor's Proposal for Restructuring Hospital Financing

- Tom McCaffery, Chief Deputy Director, Department of Health Services

Public Hospitals Perspective

- David Carroll, Director of Finance, CA Association of Public Hospitals & Health Systems
- William Walker, MD, Director, Health Care Agency for Contra Costa County
- Douglas Bagley, CEO, Riverside County Regional Medical Center

University of California Hospital Systems

- William Gurtner, Vice President, Clinical Services Development, University of California, Office of the President
- Claire Pomeroy, Vice Chancellor, Human Health Sciences, University of California Davis, and Dean, University of California Davis School of Medicine

Private Essential Access Hospitals Perspective

- Catherine K. Douglas, President & CEO, Private Essential Access Community Hospitals
- Carol Lee Thorpe, President, Community Services, Saint Francis Medical Center, Lynwood
- Bruce Satzger, President, Community Hospital of San Bernardino

II. Panel to Discuss the Proposed Expansion of Managed Care Panel

Governor's Proposal for Expansion of Managed Care

- Tom McCaffery, Chief Deputy Director, Department of Health Services

Perspective of the County Organized Healthcare Systems (COHS)

- Richard Chambers, CEO, CalOPTIMA & Chair of the CA Association of Health Insuring Organizations

Perspective of the Local Initiatives

- John R. Hackworth, PhD, CEO, Health Plan of San Joaquin
- Sylvia Gates Carlisle, M.D., Health Plan of San Joaquin
- Leona Butler, CEO, Santa Clara Family Health

Perspective of the California Association of Health Plans

- Joan Bovee, Legislative Advocate, California Association of Health Plans

Perspective of Other Representatives

- Ted Mazer, M.D., Private Practice
- Marilyn Holle, Senior Attorney, Protection and Advocacy, Inc.

III. Panel to Discuss the Proposed Use of Premiums

- Rene Mollow, Associate Director of Health Policy, Department of Health Services
- Angela M. Gilliard, Western Center on Law & Poverty, Inc.
- Deena Lahn, Policy Director, Children's Defense Fund--California
- Patricia Samuelson, M.D., Medical Director, Mercy Clinic--Norwood

IV. Additional Public Comment

- Public testimony as time permits on a first come basis. Written comments addressed to the Subcommittee are also welcomed.

Senate Budget & Fiscal Review,

Subcommittee #3
on Health and Human Services

Senator Denise Ducheny, Chair

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Governor's Proposed Medi-Cal Redesign:
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February 17, 2005

Background Materials Prepared by
Senate Budget & Fiscal Review Committee
(Diane Van Maren)

Summary and Analysis of
Administration's Medi-Cal Redesign Proposal
(Hospital Finance Restructuring, Managed Care and Premiums)

I. Key Components to the Administration's Proposal for Medi-Cal Redesign.

The Governor's Medi-Cal Redesign consists of six components, as shown in the table below. The proposal would require considerable state statutory change, as well as approval by the federal Centers for Medicare and Medicaid (CMS) for certain components that require a federal Waiver, such as the hospital finance restructuring component, managed care expansion, and the premium proposal.

The underlying fiscal assumptions offered by the Administration for each of these components are evolving with critical questions yet to be fully answered, particularly regarding the restructuring of hospital financing, expansion of Medi-Cal Managed Care, and the premium proposal.

Proposed Medi-Cal Redesign
2005-06 to 2008-09 General Fund Impact
(State Support & Local Assistance Amounts)
(Dollars in Thousands)

Proposed Redesign Component	2005-06	2006-07	2007-08	2008-09	Total
1. Medi-Cal Managed Care Expansion	$3,412	$40,098	$54,653	($85,487)	$12,675
2. Restructuring Hospital Financing	686	686	686	686	2,744
3. Capitating Dental Services	(24,843)	(25,325)	(25,325)	(25,325)	(100,818)
4. New Medi-Cal Premiums	6,847	(4,903)	(22,050)	(22,050)	(42,155)
5. Single Point of Entry Changes	2,126	(7,097)	(7,097)	(7,097)	(20,315)
6. County Performance Monitoring Standards	612	2,712	2,712	2,712	8,748
Totals	**($11,160)**	**$6,171**	**$3,579**	**($136,561)**	**($139,121)**

All of the above components will be discussed during Subcommittee hearings, as well as in joint hearings with the Senate Health Committee, during the course of the 2005-06 Legislative Session.

Today's hearing is focused on the hospital finance restructuring, managed care expansion and premium payment components of the Administration's Medi-Cal Redesign proposal.

II. Proposed Hospital Finance Restructuring *(Pages 3 to 10)*

A. California Needs Federal Funding Assistance for Hospitals: **Federal Medicaid financing**, presently provided through the state's Disproportionate Share Hospital Program (SB 855 funds), the Emergency Services and Supplemental Payments Program (SB 1255 funds), Graduate Medical Teaching Program, and the Capital Project Debt Reimbursement Program, **is an essential ingredient to California's overall health care system. Without these supplemental federal funds, California's hospital system would indeed collapse.**

California currently receives just over $2 billion for these supplemental federal funds as shown below:

(1) $1.033 billion Disproportionate Share Hospitals;

(2) $806 million for the Emergency Services and Supplemental Payments Program;

(3) $66.2 million for Graduate Medical Teaching Program; and

(4) $97.4 million for the Capital Project Debt Reimbursement Program.

Presently these supplemental federal fund programs operate through the use of "Intergovernmental Transfers" (IGT) and the state's existing Selective Provider Contract Waiver. Under the IGT process, governmental entities which operate hospitals—counties, the UC system, and hospital districts—transfer a specified amount of funds to the state by means of intergovernmental transfers. The state places these transfers into a special fund and then obtains federal matching funds. **No General Fund support is provided for this purpose.**

B. The President's Budget and Ongoing Discussions with the Federal CMS: The Schwarzenegger Administration **has been having ongoing discussions** with the federal Centers for Medicare and Medicaid (CMS) regarding California's supplemental federal funding programs and the state's Selective Provider Contract Waiver **since June 2004**. The federal CMS had intimated to the Schwarzenegger Administration that California's existing system of IGTs must be restructured due to continued concerns with the process.

To-date the only agreement that has been reached is that the state did receive a six-month federal extension for the Selective Provider Contract Waiver. This extension will continue the existing federal funding stream only until June 30, 2005.

The President's proposed budget, released on February 7, 2005, does not bode well for California. His budget proposes a reduction of $60 billion over ten years to Medicaid spending, including "inappropriate" IGTs. Among other reductions, it proposes **(1)** to curb the use of IGTs by $4.6 billion in five-years and $11.9 billion in ten-years, and **(2)** limit federal reimbursement for government providers to no more than the cost of providing services, which in effect, would reduce the Upper Payment Limit (UPL) for public hospitals ($1.2 billion in five-years and $3.3 billion in ten-years). **It should be noted that IGTs are legal and are in federal law.**

The outcomes from the negotiations with the federal CMS are truly the linchpin of the Medi-Cal Redesign.

C. Overview of Administration's REVISED Proposal: As a result of confidential discussions with the federal CMS, the Administration has **recently changed its January 2005 proposal.** However the DHS states that no agreements have as yet been made.

The Administration is seeking to obtain agreement with the federal government within the next few days or weeks. There are still many moving parts to the Administration's revised, draft proposal. In the end, any proposal would require (1) state statutory changes, **(2)** submittal of a five-year Waiver to the federal government, and **(3)** federal approval of the Waiver, along with any federal "conditions" that may be imposed.

Based on preliminary estimates, it appears that, besides making significant changes in order for California to maintain its baseline receipt of supplemental federal funds, the *potential* federal fund increases are: (1) $226 million (federal funds) that may be obtained through the "DSH swap", as discussed below, and **(2)** $193 million (federal funds) for certain indigent health care expenditures. **No new state General Fund support is proposed.**

Therefore a total of about $419 million in new federal funds *may be* available under this revised proposal. Clearly, this is less than the originally anticipated $700 million in new federal funds.

The core aspects of the revised proposal are as follows:

- **Retain the Selective Provider Contracting Program** to negotiate hospital inpatient rates as presently done.
- **Utilize a financing mechanism called "Certified Public Expenditures" (CPEs), instead of solely relying on IGTs, to draw the supplemental federal fund match. The CPE mechanism would be implemented at 21 public hospitals, including UC hospitals. These CPEs would include expenditures for indigent health care for 13 counties, as well as hospital outpatient expenditures.**
- **Establish a "Safety Net Care Pool"** which would be broadly defined to fund health care services to Medi-Cal enrollees and uninsured, indigent populations (13 counties ***and*** possibly some of the state's programs). **About $1.8 billion (federal funds) would be available for this purpose.**
- **Deposit *all* of the Disproportionate Share Hospital (DSH) funds and supplemental federal funds (SB 1255), along with some technical funding adjustments, into the "Safety Net Care Pool".**
- Eliminate the $85 million transfer from the public hospitals to the state (i.e., state administrative fee) which the state had used to backfill for General Fund support.
- Fund private hospitals (Private Essential Access Hospitals—PEACH) using "regular" Medi-Cal funding (state General Fund and federal funds), in lieu of using DSH funds. (**The Administration refers to this as the "DSH swap".)**
- **De-link Medi-Cal Managed Care Program inpatient hospital day payments from the receipt of supplemental federal funds.**

Each of the key components of the Administration's proposal are discussed in more detail below.

1. Selective Provider Contracting Program (SPCP) Waiver

A. Background—Existing Program Saves General Fund and Federal Dollars: Through this program, the state contracts on a competitive basis with **certain hospitals** (about **229 hospitals** mainly in urban areas) that want to provide inpatient services to Medi-Cal recipients at **a negotiated per diem rate for all hospital inpatient services**.

The CA Medical Assistance Commission (CMAC) negotiates rates with the hospitals through confidential discussions. A key requirement of the program is to ensure sufficient hospital beds to serve the Medi-Cal population. This program has been in existence since 1982 and has saved billions in state and federal funds.

The average statewide Medi-Cal *contract* rate was $1,029 per day using 2003-04 data. The average statewide Medi-Cal *non-contract* rate was $2,080 per day (2003-04 data). As such, for 2003-04 alone, the General Fund savings attributable to the SPCP are $703 million. In other words, these are funds that would have been spent had California not implemented the SPCP.

According to CMAC, the average rate a SPCP contract hospital receives has increased about 3.5 percent per year on a compounded basis, or by 100.4 percent from 1984 through 2003. In contrast, to the historical change in the average payment rate to *non-contracting* hospitals, the average payment from 1984 to 2003 has increased by 277.5 percent or about 6.9 percent per year on a compounded basis.

Below is a table that shows the average rates for SPCP contract hospitals.

Table: SPCP Contract Hospital Rates

Year	1990	1993	1996	2000	2001	2002	2003
Statewide	**$651**	**$780**	**$836**	**$905**	**$957**	**$991**	**$1,029**
Southern	$662	$789	$837	$891	$921	$952	$964
SF Bay Area	$682	$816	$873	$985	$1,104	$1,178	$1,218
Other	$620	$748	$815	$905	$962	$999	$1,060

Southern includes: Los Angeles, Orange, Riverside, San Bernardino and Ventura.

SF Bay Area includes: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma.

With respect to Medi-Cal inpatient hospital days for 2003-04, almost 90 percent of the patient days were provided by SPCP contract hospitals. Hospitals in open areas and non-contract hospitals provided the remaining 10 percent of total inpatient acute care days in Medi-Cal.

B. SPCP under the Administration's Revised Proposal: **In essence, the SPCP would remain the same over the five-year proposed Waiver period.** Hospitals that choose to contract would negotiate with CMAC for an inpatient hospital rate and would likely be eligible to receive supplemental federal funds. Non-contract hospitals would receive a statewide rate.

2. Use of "Certified Public Expenditures" (CPE) for Public Hospitals:

A. Background—Existing Use of CPE: Several programs within Medi-Cal currently use certified public expenditures to draw down federal funds. Some of these include: (1) the Medicaid Administrative Activities (MAA), (2) Targeted Case Management (TCM), and (3) Mental Health Managed Care Program. **The specific requirements for each of these CPE programs vary, and are contingent on either a federally approved Waiver or a federally approved State Plan Amendment. In addition, the President's proposed budget seeks to limit some of these programs, such as MAA and TCM.**

B. Background—How Would the CPE Work?: Under the proposed CPE, **public hospitals and UC hospitals would "certify" they have expended public funds to provide services to indigent individuals and Medi-Cal individuals.** The CPE covered services would probably include inpatient and outpatient hospital services, clinic services, physician services provided in hospitals and clinics, and other ancillary services, such as durable medical equipment. **The CPE funds would be placed into the "Safety Net Care Pool" and be used to draw federal supplemental funds.**

The cost of serving indigent individuals and Medi-Cal individuals in these hospitals would be determined by using more restrictive federal Medicare cost reports, not existing state OSHPD reports as presently done. The Administration intends to seek additional reasonable cost categories from the federal CMS that more comprehensively reflect the costs of doing business in California hospitals; however this outcome is presently unknown.

Mechanically, the public entities would certify that expenditures being claimed meet federal government requirements and that any misrepresentation constitutes a violation of federal law. Each hospital must then sign and date a certification form that is submitted to the DHS along with a claim for federal funding. This new process may require data system and accounting changes at each of the impacted hospitals.

The state is responsible to the federal government for the accuracy and validity of the claims for federal funds. Generally, the state would be completing desk reviews and audits of hospitals in order to verify each of the hospitals CPE information. **However, a comprehensive CPE validation process has not yet been designed by the DHS.**

In the event that a hospital's actual cost report for a year, as finally accepted by the state, shows a higher or lower CPE, the difference would be accounted for by adjustments to subsequent payments to the hospital. This provision would be contained within the Waiver document.

C. Potential Concerns with CPE Approach: A key concern with this approach is how the federal CMS will define the cost methodology. **This definition could potentially limit the level of CPE that can be claimed for federal financial participation.** In order to achieve the level of federal funding needed, both the Administration and public hospitals believe we need to count expenditures for indigent health care. However it is unclear if the federal CMS will enable California to include these health care expenditures.

Another concern is that the CPE model may not work for all of the 21 hospitals. Some of the hospitals may have "higher" CPEs (meaning they currently draw down less supplemental federal funds than they have in matching indigent care expenditures) while others may have "lower" CPEs (currently receive more supplemental federal funds). Therefore in order to fully utilize available federal funds, some redistribution (from an accounting standpoint) may need to be done. This proposition could become quite complex and raise subsequent issues regarding differences between hospitals and regions.

3. "Safety Net Care Pool":

Description of Safety Net Care Pool: **This is a completely new concept** which just came forth from the Administration and is modeled after a Waiver completed by Massachusetts and approved by the federal CMS.

Under this concept, a "pool" would be established for use by California in providing health care services to Medi-Cal enrollees and uninsured, indigent populations (i.e., 13 counties *and* possibly some of the state's programs). The Administration wants to have a broad definition of how this pool can be used in order to maintain flexibility under the proposed Waiver.

Though no definitive federal dollar amount has been provided by the Administration since negotiations are ongoing with the federal CMS, the Administration contends that about $1.8 billion in federal funds would be potentially available in the Safety Net Pool.

Generally, the "pool" would consist of federal funds that are primarily accessed through the use of CPEs and through a limited level of IGTs (from public hospitals, or the UC system, *if available*). The primary intended use of the "pool" funds is to cover health care services to the uninsured and Medi-Cal populations provided in hospitals and through public programs.

This federal pool of funds would be capped based on an agreed to federal budget neutrality provision. (This is discussed further below.)

The federal revenue for the "pool" would consist of:

(1) California's entire Disproportionate Share Hospital (DSH) allocation from the federal government for that year (DSH would loose its identity);

(2) Other supplemental federal funds (SB 1255) along with some technical adjustments;

(3) A federal fund match for some indigent care expenditures (potentially);

(4) Up to $250 million (federal funds) if a limited IGT can be used to draw down the federal funds and public entities, such as the public hospitals or UC system, have funds available for this purpose. (The $250 million represents a portion of the amount that is available in the Upper Payment Limit for private hospitals); and,

(5) A growth trend factor to be calculated annually over the life of the Waiver, commencing from a defined base level amount and rolling forward. This growth factor would not apply to the DSH allocation.

In order to access this "pool", a non-federal share of payments needs to be made. The "non-federal share" payments (i.e., funds used to drawn down the federal revenues) **would consist of the following:**

(1) CPEs for indigent health care costs from the 21 hospitals;

(2) Intergovernmental transfers (IGTs) from public hospitals for payments to public and private hospitals for uncompensated care costs that are between 100 percent and 175 percent of costs (pertains to the Upper Payment Limit to enable private hospitals to draw down up to $250 million in federal funds); and

(3) ***Possibly*** state General Fund moneys or special fund moneys for certain health care services provided to indigents (i.e., non-Medi-Cal), such as California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), AIDS Drug Assistance Program (AIDS) or others. This aspect of the proposal is unknown at this time.

B. How Would the Safety Net Care Pool Work? The Administration **views the distribution of the Safety Net Care Pool as being a discussion that will occur *after*** the federal CMS conceptually approves the state's Waiver.

However, distribution of the Safety Net Care Pool is a significantly issue for the hospitals, particularly the public hospitals. The public hospitals are facing significant uncertainty, particularly with all DSH funds being transferred to the "pool" and with the proposed shift to CPEs.

In response to this concern, the Administration states that public hospitals would be "held harmless". However, there is no written reference to this in their proposal, nor has the Administration provided any fiscal detail on this topic. Therefore the risk to public hospitals is substantial.

4. De-Linking of Managed Care Inpatient Days: The federal revenues provided to the Safety Net Care Pool would be capped and the payments for inpatient hospital services to Medi-Cal eligibles would be subtracted out, including those payments to private hospitals.

Under this concept, the money would follow the Medi-Cal patient. The money being used for the Medi-Cal Managed Care patient would be included in the Managed Care Waiver (separate and apart from a Hospital Finance Restructuring Waiver). The supplemental federal funds (SB 1255 funds) now used for indigent care would go into the Safety Net Pool, as described above, and be available and unlinked to fee-for-service days or the movement to Medi-Cal Managed Care.

The Administration contends that this de-linking means that public hospitals would not be financially affected by any further movement to Medi-Cal Managed Care. The Administration notes that 70 percent of a hospital's expenditures are variable, not fixed because of labor funding and related items. As such, the Administration states that under the CPE concept, hospitals will be getting 50 percent of their costs funded by

federal funds. Under our current per diem rates to public hospitals, we pay only 50 percent (state and federal funds) of their Medi-Cal costs. Therefore according to the Administration, moving to the CPE model and paying 50 percent (federal funds) gets hospitals the same payment amount as they currently receive.

Public hospitals would likely maintain that Medi-Cal patients, and the reimbursement they bring, assist in stabilizing their funding stream. Otherwise the entire funding relationship becomes a county-federal partnership with limited or no state funding responsibility.

The federal CMS wants this de-linking because (1) they would want to share in any savings that result from the expansion of managed care, and (2) they don't want to pay twice for the service (i.e., fee-for-service and managed care payments).

5. Private Hospital Funding (DSH Swap). Under the Administration's proposal, **private hospitals would no longer be part of the DSH arrangement but would instead, receive "regular" Medi-Cal funding (state General Fund with a federal match).**

According to the Administration, this "DSH swap" enables the state to obtain about $226 million (federal funds) more from our existing DSH allotment. This is because in the past, some public hospitals had to receive higher DSH payments to recoup (net out) their IGT payment (remember that the IGT payment was needed in order to draw DSH for the private hospitals). Since DSH is losing its identity and IGTs would be used to a lesser degree, it makes the $226 million available.

The DSH "administrative fee" (i.e., the $85 million the state takes to backfill for General Fund) would be eliminated as part of this DSH swap. No General Fund increase would occur however because of the interactions with the DSH swap and SPCP Program contract per diem payments made to public hospitals.

6. Upper Payment Limits for Inpatient Services:

Federal law establishes maximum rates that can be paid for hospital inpatient and hospital outpatient services. The federal government defines these "Upper Payment Limits" (UPL) as the amount of money Medicare would pay for the same set of services provided by Medicaid (Medi-Cal). There are limits in the aggregate for the state, as well as limits for each group of services, such as hospital inpatient services, as well as others.

There is also an overall UPL limit for a group of hospitals. Each hospital is in one of three categories—(1) state owned and operated facilities, (2) non-state owned and operated facilities, or (3) private facilities. The federal government has classified the UC hospitals as "state owned and operated". County and district hospitals are in the "non-state" category. PEACH hospitals are in the private facilities category.

The Administration's Waiver proposal contains a UPL adjustment factor for the UC hospitals that is needed in order to fully recognize costs and to utilize the CPE model.

7. Federal Cap—Budget Neutrality Calculation: Generally, the federal revenue cap would be based on a calculation of what California's expenditures would have been for Medicaid (Medi-Cal eligible) inpatient hospital services in the absence of this Waiver.

This calculation is quite complex and hinges on obtaining federal CMS agreement on several components, including **(1)** maintaining the Upper Payment Limit (UPL) for public hospitals, **(2)** recognizing a technical adjustment in the Upper Payment Limit for state hospitals, **(3)** maintaining a specified level for California's DSH allotment, **(4)** obtaining an indigent health care funding amount, **(5)** maintaining certain payments for private hospitals, **(6)** maintaining certain payments for non-contract inpatient hospitals, **(7)** approval of increased payments to private hospitals through the use of a limited IGT, and **(8)** approval of a growth factor.

III. Proposed Managed Care Expansion *(Pages 11 to 15)*

A. Summary of Existing Medi-Cal Managed Care System: The DHS is the largest purchaser of managed health care services in California. Currently, some form of **Medi-Cal Managed Care serves about 3.2 million Medi-Cal enrollees**, primarily families and children and is **in 22 counties**. **Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities.**

The state has federal approval to operate this *existing* system under State Medicaid Plan authority.

The Medi-Cal Managed Care system utilizes three types of contract models— (1) the Two Plan, **(2)** the County Organized Health Systems (COHS), and **(3)** Geographic Managed Care (GMC). About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties. There are five COHS (federal law limit) that serve eight counties. The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS.

In addition, certain services are "carved-out" of the Two Plan and GMC models, as well as some of the COHS's. Most notably, Mental Health Managed Care, and the California Children's Services (CCS) Program are "carved-out", except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

Background--Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

Plan Name	County	June 2003 Enrollment
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Background—Geographic Managed Care (GMC): The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. **Sacramento and San Diego counties contract with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.**

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

Background—County Organized Health Systems (Eight Counties): Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model).

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county.

As noted in the chart below, **about 540,000 Medi-Cal recipients** receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. **It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model. As such, the state is close to meeting this enrollment limit.**

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

B. Overview of the Administration's Proposal: The Administration's Medi-Cal Managed Care expansion would be achieved through **a phased-in process over a twelve to eighteen month period commencing in January 2007.** The Administration's proposal would require **(1)** state statutory changes, **(2)** approval of a federal Waiver, and **(3)** adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent.

Dual eligibiles (i.e., Medi-Cal and Medicare) would be excluded from mandatory enrollment except in COHS and in certain newly proposed Long-Term Care Integration projects.

The table below displays the Administration's assumed fiscal impact. The DHS notes that time is needed to assure that appropriate delivery systems are in place before managed care is expanded. As such, initial costs will be incurred before out-year savings are realized.

In addition, particularly in 2007-08, the DHS states that as individuals transition from fee-for-service to managed care, the payment of costs for services already rendered under fee-for service are due at the same time as the monthly capitation arrangements to managed care plans (capitation payments are made for the month of enrollment without payment lags). Therefore, costs are incurred as the transition transpires.

Table—Administration's Fiscal Impact Summary from Managed Care Expansion

Fiscal Year	Assumed Increase In Enrollees (average mthly)	Local Assistance (General Fund)	State Support (General Fund)	Net Total (General Fund)
2005-06	0	$150,000	$3,262,000 (47.5 positions)	$3,412,000
2006-07	61,000	$36,836,000	$3,262,000	$40,098,000
2007-08	538,785	$51,390,000	$3,262,000	$54,652,000
2008-09	820,239	($88,749,000)	$3,262,000	($85,487,000)

If the Managed Care expansion is fully implemented as proposed, about 60 percent of all Medi-Cal recipients would be enrolled in an organized delivery system.

In addition to individuals who would not be enrolled in managed care, such as rural residents, the DHS states that about 17 percent of all applicants who qualify for Medi-Cal managed care are in "transition". These individuals in "transition" are either in the process of being determined eligible for Medi-Cal or are awaiting enrollment into managed care. During this transition period, health care services are being provided on a fee-for-service basis.

The proposed expansion assumes the following key components:

1. Expansion to 13 New Counties. The Administration would expand Medi-Cal Managed Care to 13 additional counties, **including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.**

The Administration assumes the following Managed Care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

2. Aged, Blind and Disabled Individuals (Mandatory Enrollment). The DHS has identified **36 Medi-Cal aid codes** which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. **It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).**

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

3. Acute and Long-Term Care Integration. The Administration also proposes implementation of Acute and Long-Term Care Integration Projects (Projects) in Contra Costa, Orange, and San Diego counties. Dual eligibles (Medicare and Medi-Cal) living in these counties would be enrolled.

The DHS states that these Projects would offer a comprehensive scope of services that manages the full continuum of health care needs, including primary care, case management, acute care, long-term care, dental services, emergency services, and drugs.

C. Staff Comments--Key Considerations and Concerns: The Administration's proposed managed care expansion **is very ambitious, particularly given the state's history with past Medi-Cal managed care expansion efforts, including recent problems in Fresno County as well as in Stanislaus County.**

The expansion into new counties, coupled with a mandatory enrollment of aged, blind and disabled individuals, is too much to accomplish successfully within the 12 to 18 month period designated by the Administration. This is particularly true when it comes to transitioning very medically involved individuals from providers they know and who know them, to a new network of providers.

Aged, blind and disabled individuals require more extensive specialty medical care services, personalized durable medical equipment, and rehabilitation therapists who have experience with serving these medically involved individuals. As such, issues pertaining to physician networks, access to durable medical equipment and related needs will need to be comprehensively addressed prior to any transition for these individuals.

If this expansion is to occur, comprehensive planning with impacted constituency groups, particularly stakeholders in the mental health and developmental disabilities communities, needs to occur. Ongoing involvement from local communities, as presently done in San Diego County, should also be a component requirement.

In addition, considerable fiscal issues, including resolution of complex hospital financing concerns and the development of meaningful managed care rates, need to be further studied and resolved if aged, blind and disabled individuals are to be required to be enrolled. If rates are not appropriate, people will not receive necessary medical services.

It is well known that the COHS have been experiencing fiscal hardship in serving these very medically-involved individuals. In fact, the Budget Act of 2004 provided a three percent rate increase to the COHS due to low operating reserves and questions of fiscal solvency.

Key factors for the state to evaluate health plan readiness of any managed care arrangement includes: (1) analysis of available service utilization and cost data; (2) network adequacy; (3) care coordination and carve-outs; (4) quality monitoring and improvement; (5) linkages with non-Medi-Cal services; (6) accessibility and availability of new treatment modalities; (7) community, provider and consumer input into the planning process; and (8) health plan and provider compliance with the Americans with Disabilities Act of 1990.

The inclusion of aged, blind and disabled individuals (36 new aid codes) would require an expanded state evaluation to determine health plan readiness**.** In conjunction with the federal CMS, the DHS would conduct readiness reviews of all Medi-Cal Managed Care plans prior to health plans becoming operational to serve this population. Specifically the DHS states that they would use the readiness model established under the COHS process. However more analysis of this approach is needed in order to discern what factors are to be measured and what quality assurances will be put into action. Clearly, more detailed discussions with constituency groups and the Legislature are needed prior to any agreements for expansion.

IV. Proposed Implementation of a Premium *(Pages 16 to 21)*

A. Background—What is the Administration's Proposal? Under this proposal, effective January 1, 2007, Medi-Cal enrollees with **incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage.**

The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

The proposed premium amounts are as follows:

- $4 per month for children under 21 years;
- $10 per month for adults; and
- $27 per month maximum for a family.

For example, a family of three with a monthly earned income of $1,306 per month would pay $24 per month for coverage or $288 annually. The required premium payment represents about 1.5 to 2 percent of the total annual income for the affected individuals.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. The DHS would contract with a Vendor to conduct the actual collection of the premiums each month.

B. What are the Criteria for Determining a Premium? Premiums will be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, **except for (1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives.

Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and
- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

However, 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). **Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.**

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Call services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

C. Who are Affected & How is Enrollment Impacted? This proposal would affect children, aged, blind and disabled individuals, and families. **A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.**

In the first year alone, **the DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled,** and thereby add to the increasing ranks of the uninsured living in California. **This is illustrated in the table below.**

It should be noted that the DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

Table—DHS' Assumptions of Who Drops Off

Eligibility Category (Fee-for-Service & Managed Care)	Total Medi-Cal Enrollees Needing to Pay	Reduction in Enrollees (Drop-Off)
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630**

D. Medi-Cal Eligibility Processing— Likely Churning of Enrollees: **The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs.**

First, under federal law, as well as SB 87 (Escutia), Statutes of 2000, individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. **As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.**

Medi-Cal re-determination processing can require considerable work on the part of counties. Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. **These administrative costs have *not* been addressed by the Administration's proposal.**

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). **This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal Managed Care. Managed Care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor** since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. **If the two systems are not in synch with each other, the state could be making Managed Care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.**

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

E. Proposed Administrative Costs Do Not Reflect All Necessary Expenditures: **The table below displays** the DHS' estimated expenditures for the administration of the premium. As noted below, they assume first year (i.e., 2005-06) implementation expenditures of $6.850 million General Fund, with on-going annual expenditures of **at least** $12.150 million General Fund.

However, not all of the expenditures are captured in the DHS' cost assumptions. First, no additional county administrative costs have been recognized for conducting Medi-Cal re-determinations as discussed above.

Second, the DHS fiscal summary assumes that counties would calculate a premium one time, and that would be it. However, in the reality of life, people may lose their job or have their hours reduced, get married, have a baby, or other related-life events that would result in them no longer having a premium requirement. **As such, additional administrative costs for calculating the premium would probably be needed.** In addition, would a family have to pay while their premiums are being re-determined? If they didn't pay, would they be inappropriately dropped off of Medi-Cal?

Third, expenditures for a contractor to *design* a premium collection system are not included, though expenditures for the actual collection of the premium are included. It is likely that development and design of an information system would be costly. **The DHS notes that it is unknown at this time what these costs would be.**

The DHS assumes that it will take at least 18 months for the "premium collection contractor" to develop a collection system and begin actual collection (assumes premiums begin to be paid as of January 1, 2007).

Table: Administrative Expenditures for Premium

Administrative Activity	Proposed Expenditures (General Fund) 2005-06	Proposed Expenditures (General Fund) 2006-07 *(1/1/2007 start)*	Proposed Expenditures (General Fund) 2007-08
I. DHS Identified Costs			
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (positions)	$650,000	$650,000	$650,000
Subtotal--DHS' total amount	**$6,850,000**	**$10,000,000**	**$12,150,000**
II. Unidentified Costs			
County Re-determination Costs		**Unknown**	**Unknown**
County Re-Enrollment Costs		**Unknown**	**Unknown**
County Premium Re-Calculation		**Unknown**	**Unknown**
County MEDS Linkage to Vendor		**Unknown**	**Unknown**
Vendor Design, Development and Maintenance of System		**Unknown**	**Unknown**
Health Plans Options Processing		**Unknown**	**Unknown**

F. Administration's Assumptions Regarding Savings: As shown in the table below, the Administration **assumes savings from the premium payments from two sources: (1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis. However as previously discussed, it is unlikely that all costs associated with administration of this program have been captured.

Table: Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

G. Administration's Proposed Implementation: The premium proposal **would require state statutory change as well as a federal Waiver.**

The Administration assumes approval by the Legislature during the 2005-06 Session and that a Waiver would be submitted to the federal CMS by December 2005. The DHS notes that the federal Waiver process might take from six to nine months from this date for approval. The Administration notes that the state contracting process typically takes 15-21 months once their Request for Proposal (RFP) is released. Therefore, the Administration assumes that premium payments and collections would begin January 2007.